Electronically Delivered

November 14, 2024

Licensee
Alltracare LLC
3641 Decatur Avenue North
New Hope, MN 55427

RE: Project Number(s) SL39510015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on October 9, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39510	A. BUILDING: _____ B. WING _____	10/09/2024

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ALLTRACARE LLC	3641 DECATUR AVENUE NORTH NEW HOPE, MN 55427

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39510015-0 On October 7, 2024, through October 9, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there was one resident receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 2 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 680		

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0 680	Continued From page 3 The findings include: The licensee's undated EPP lacked evidence of the following required content: - process for emergency preparedness (EP) collaboration; and - emergency officials contact information to include local EP staff. On October 8, 2024, at 11:50 a.m., licensed assisted living director (LALD)-C stated they created the licensee's EPP following Appendix Z and the risk assessment for the facility. LALD-C stated it was difficult to apply the 144G statue requirements to the facility due to being a smaller facility. The licensee's 2.01 Policies & Procedures Overview policy dated April 18, 2024, indicated the licensee would maintain an emergency plan accordance to state and federal guidelines. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 4 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 810		

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0 810	Continued From page 5 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 08, 2024, at 12:45 p.m., agent/unlicensed personnel (A/ULP)-A and licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this facility and provide complete actions for employees to take in the event of a fire or similar emergency. TRAINING: The provided records were for fire safety training offered by third-party online software that could not be modified to include the facility-specific fire safety plans. A/ULP-A and LALD-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 6 (21) days	0 810		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family;	01370		

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01370	Continued From page 7 (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training was completed and documented for three of three unlicensed personnel ((ULP)-B, ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired September 22, 2023, as a direct care staff (DCS). ULP-B's personnel record lacked evidence of completed training for maintenance of a clean and safe environment. ULP-E ULP-E was hired March 23, 2024, as a DCS. ULP-E's personnel record lacked evidence of completed training for maintenance of a clean and safe environment. ULP-F	01370		

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01370	Continued From page 8 ULP-F was hired November 6, 2023, as a DCS. ULP-F's personnel record lacked evidence of completed training for the following: - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. On October 8, 2024, at 11:29 a.m., licensed assisted living director (LALD)-C stated the missing core training was an oversight as the licensee was aware of the statue. The licensee's undated Qualification, Training and Competency policy indicated ULPs performing delegated nursing tasks in an assisted living facility must have completed training and demonstrated competency by successfully completing a written or oral test of the topics in 144G.61, subd 2 at the time of hire. Also, the policy indicated each ULP who had successfully completed the training would be provided a written certificate and the documentation would be maintained in the personnel file. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel	01380		

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01380	Continued From page 9 providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training was completed and documented for one of three unlicensed personnel ((ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired November 6, 2023, as a direct care staff (DCS). ULP-F's personnel record lacked evidence of completed training for basic knowledge of body	01380		

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01380	Continued From page 10 functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. On October 8, 2024, at 11:29 a.m., licensed assisted living director (LALD)-C stated the missing core training was an oversight as the licensee is aware of the statue. The licensee's undated Qualification, Training and Competency policy indicated ULPs performing delegated nursing tasks in an assisted living facility must have completed training and demonstrated competency by successfully completing a written or oral test of the topics in 144G.61, subd 2 at the time of hire. Also, the policy indicated each ULP who had successfully completed the training would be provided a written certificate and the documentation would be maintained in the personnel file. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470		

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01470	Continued From page 11 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01470		

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01470	Continued From page 12 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for three of three unlicensed personnel ((ULP)-B, ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-B ULP-B was hired September 22, 2023, as a direct care staff (DCS). ULP-B's transcript dated October 7, 2024, indicated ULP-B completed training on Assisted Living Bill of Rights on September 16, 2024, which was completed 360 days after the hire date. ULP-E ULP-E was hired March 23, 2024, as a DCS. ULP-E's transcript dated October 8, 2024, indicated ULP-E completed the following training: - Assisted Living Bill of Rights on September 15,	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39510	A. BUILDING: _____ B. WING _____	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLTRACARE LLC	3641 DECATUR AVENUE NORTH NEW HOPE, MN 55427

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01470	Continued From page 13 2024, which was completed 176 days after the hire date; and - Guide to Assisted Living, which included consumer advocate services on September 15, 2024, which was completed 176 days after the hire date. ULP-F ULP-F was hired November 6, 2023, as a DCS. ULP-F's transcript dated October 8, 2024, indicated ULP-F completed the following training: - Assisted Living Bill of Rights on September 15, 2024, which was completed 314 days after the hire date; and - person-centered care principles on September 15, 2022, and again on April 11, 2024. The training completed on September 15, 2022, was not transferrable due to orientation requirement; and the training completed on April 11, 2024, was completed 157 days after the hire date. On October 8, 2024, at 11:25 a.m., agent/unlicensed personnel (A/ULP)-A stated the licensee used a checklist provided by Educare (common education program) and ensured the check list matched the orientation requirements per statue; the missed items could have been an oversight. The licensee's undated Facility Employee Orientation policy indicated all employees would complete an orientation on topics required by Minnesota statues and rules for assisted living. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01530	Continued From page 14	01530		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees received eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for two of two unlicensed personnel ((ULP)-B, ULP-F) that had worked at least 160 hours for the licensee.	01530		

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01530	Continued From page 15 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-B ULP-B was hired September 22, 2023, as a direct care staff (DCS). On October 9, 2024, at 1:57 p.m., agent/unlicensed personnel (A/ULP)-A verified ULP-B had worked 160 hours for the licensee on May 20, 2024. ULP-B's transcript dated October 7, 2024, included the following initial dementia care training: - Dementia -Person-Centered Care (0.75 hours) completed on June 12, 2024; - Dementia 1 -Introductions and Overview (1 hour) completed on September 15, 2024; - Dementia 2 - Communication (1.25 hours) completed on September 15, 2024; - Dementia 3 - Activities of Daily Living (1 hour) completed on September 15, 2024; - Dementia 4 - Behaviors vs Symptoms (1 hour) completed on September 16, 2024; - Dementia Management and Abuse Prevention - BELTSS MN25-5002 (1 hour) completed on October 14, 2023; and - Dementia Series - BELTSS MN25-5003-AA Recognized (3 hours) completed on October 23, 2023.	01530		

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01530	Continued From page 16 ULP-B had four hours completed within 160 hours of working for the licensee. ULP-B's personnel record lacked the required eight hours of dementia care training within 160 hours of working for the licensee. ULP-F ULP-F was hired November 6, 2023, as a DCS. On October 9, 2024, at 1:57 p.m., Agent/unlicensed personnel (A/ULP)-A verified ULP-F had worked 160 hours for the licensee on June 21, 2024. ULP-F's transcript dated October 8, 2024, included the following initial dementia care training: - Dementia - A Refresher (1 hour) completed on March 27, 2024; - Dementia - A Refresher (1 hour) completed on August 26, 2022; - Dementia - Activities - Bathing (0.75 hours) completed on September 25, 2024; - Dementia - Activities - Chores, Working, and Volunteering (0.75 hours) completed on September 25, 2024; - Dementia - Activities - Dressing and Grooming (0.75 hours) completed on September 25, 2024; - Dementia - Activities - Hydration, Nutrition, Eating, and Dining (0.75 hours) completed on September 25, 2024; - Dementia - Activities - Toileting (0.5 hours) completed on September 26, 2024; - Dementia - Communication - Overview (1 hour) completed on September 26, 2024; - Dementia 1 -Introductions and Overview (1 hour) completed on February 24, 2021; - Dementia 1 -Introductions and Overview (1	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01530	Continued From page 17 hour) completed on September 27, 2024; - Dementia 2 - Communication (1.25 hours) completed on September 27, 2024; and - Dementia 3 - Activities of Daily Living (1 hour) completed on September 25, 2024. ULP-F had one hour completed within 160 hours of working for the licensee and one hour that had been completed within 18 months prior to the hire date. ULP-F's personnel record lacked the required eight hours of dementia care training within 160 hours of working for the licensee. On October 8, 2024, at 11:32 a.m., licensed assisted living director (LALD)-C indicated the licensee was aware of the required eight hours of initial dementia care training within the first 160 hours of working for the licensee and stated it was an oversight for not having these completed within the required time frame. The licensee's undated Dementia Care Training policy indicated direct care employees would complete 8 hours of dementia care training prior to being able to provide direct care unless there is another employee on site who had completed the training. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *10/08/24*
Time: 10:32:21
Report: 1023241225

Food and Beverage Establishment Inspection Report

Location:
Alltracare LLC
3641 Decatur Ave N
New Hope, MN55427
Hennepin County, 27

Establishment Info:
ID #: 0043692
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-500 Responding to contamination events

2-501.11 ***** Priority 2 *****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

SENT SAMPLE PLAN INCLUDING CORRECT CHLORINE CONCENTRATION WITH REPORT.

Comply By: 10/08/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SPRAY
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: ANSI 184
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Type: Full
Date: *10/08/24*
Time: 10:32:21
Report: 1023241225
Alltracare LLC

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	0

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023241225 of 10/08/24.

Certified Food Protection Manager: MARVELOUS ANAKO

Certification Number: 123834 Expires: 05/11/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
SALOME ASETTO
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us